Patient's Authorization to Release Medical Records

Please provide complete and accurate information when submitting this form. ***Sitka Medical Center*** will only process valid and complete authorization forms.

Patient's Name: ______________________________ Date of Birth: ______________

Address: ______________________________ City: ______________ State: ______Zip: ________

Telephone Number: ______________________________Social Security Number: ______________________

I authorize release of my health care information concerning *(please check off at least one of the following):*

1. ___ All health care records 2. ___ Treatment of *(please identify condition):* ______________________

3. ___ Treatment received on the following dates: from: ____________________ to: ____________________

4. ___ Other *(please describe):* ____

Sensitive records require specific patient authorization. Please intial the appropriate records requested:
I authorize the information listed below to be used, disclosed or received:

___ Mental Health ___ STD's including HIV/AIDS____ Drug and/or alcohol abuse diagnosis, prognosis, or treatment.

Release:

I authorize ***Sitka Medical Center*** to release my personal health care information ***to:***

Name: ______________________________Dr: ______________________________

Address: ______________________________ City: ______________ State: ______Zip: ________

Telephone Number: ______________________________Fax Number ______________________________

Request:

I authorize: Name: ______________________________Dr: ______________________________

Address: ______________________________ City: ______________ State: ______Zip: ________

Telephone Number: ______________________________Fax Number ______________________________

To release my private health information as identified above to: **Sitka Medical Center,**
7oo Katlian St., Suite E,
Sitka, Alaska 99835

Please list the purpose or need of your health information: Please check one

1. ___ Transfer of care 2. ____ Moving 3.____ Seeing referred physician 4. ____ Other ______________

SITKA MEDICAL CENTER

700 Katlian St., #E, Sitka, Alaska 99835 ✦ 907-747-5861 (Phone) 907-747-5415 (Fax)

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I understand that I have the right to revoke this authorization, in writing, at any time. I understand that a revocation is not effective when Sitka Medical Center has already relied on the use or disclosure of the health information or if my authorization was obtained as a condition of obtaining insurance coverage and the insurer has a legal right to contest a claim. To revoke an authorization, write a letter to Sitka Medical Center Medical Records department.

I understand that information used or disclosed pursuant to this authorization may be disclosed by the recipient and may no longer be protected by federal or state law.

I understand that I do not have to sign this authorization in order to get health care benefits (treatment, payment, enrollment, or eligibility for benefits) except when (1) my treatment is related to research, or (2) health care services are provided to me solely for the purpose of creating protected health information for disclosure to a third party, or (3) an authorization is required for health plan eligibility or enrollment or a risk rating determination. Failure to sign an authorization may result in inability to obtain certain benefits in these cases.

I acknowledge I have fully reviewed and understand the contents of this authorization form. My signature below indicates that I herby agree and authorize to release of patient health information to the above named person or organization.

Signature: ____ Date: ____________________

If this authorization form is signed by a personal representative for the individual patient:

Personal Representative's Name: ____

Signature: _____________________________________ Relationship: ___________________

This authorization is valid for one year from date unless specified ____________________ (date).

✶✶In most cases a first request for record copies has no charge. Sitka Medical Center reserves the right to charge for additional requests for the same records.

Done by: ___________________

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